



Request for Information on Pilots for Beneficiaries Dually Eligible for Medi-Cal and Medicare



**Submitted To:**

**State of California—Health and Human Services Agency  
Department of Health Care Services**

Kevin Morrill, Chief  
Office of Medi-Cal Procurement, MS 4200  
P.O. Box 997413, Sacramento, CA 95899-7413  
(916) 552-8006

VIA E-MAIL: [omcprfp9@dhcs.ca.gov](mailto:omcprfp9@dhcs.ca.gov).

**Submitted By:**

**Addus HealthCare, Inc.**

2401 S. Plum Grove Road

Palatine, IL 60067

**Contacts:**

Darby Anderson, Divisional VP

(312) 663-4647

Diane Kumarich, VP Natl. Contracts

(847) 303-5300

## Executive Summary

Addus HealthCare appreciates the opportunity to respond to the Department's request for comments and suggestions on the structure of this pilot project. We have provided a summary of our company, services and perspective. We have also provided an overview of our Community Case Manager Extension Program which we believe should be an integral part of this pilot. Finally, as requested in the RFI, we have also provided answers to the specific questions listed.

Addus is proud to be a nationally recognized provider of high quality Home and Community Based Services in 19 states including **California**. The company's demonstrated provision of quality services has resulted in a steady pattern of growth in contractual, as well as, private-pay and contracted managed care services. Our breadth of services includes In-Home Aide, Personal Care, Attendant Care, Care Management, Respite, Transportation, Chore/Housekeeping, Adult Day Care, Licensed Home Health Services, and Family Support Services. In total, we currently provide over 12,000,000 service hours to over 50,000 Consumers, from 125 offices through the dedication of more than 13,000 employees in the states of North Carolina, Alabama, Arkansas, California, Delaware, Georgia, Idaho, Illinois, Indiana, Mississippi, Missouri, Montana, Nevada, New Mexico, North Carolina, New Jersey, Oregon, Pennsylvania, South Carolina, and Washington.

Addus' 30 years of experience serving the elderly and disabled, the economically disadvantaged, and minority populations has made our company all too familiar with the very real situations of older adults and disabled persons who suffer trauma, have a chronic illness or disability that makes them vulnerable to exploitation or abuse, who are gravely affected by the loss of a spouse or partner, who have no family or an unsupportive family and are not able to access or are unaware of available resources. In some cases, they may have accessed services through a number of venues all of whom are duplicating what could be a better managed complement of care. For this reason, Addus has carefully developed a coordinated, effective program to have maximum impact in delivering Risk Assessment and coordinated Home and Community Based Services to those elderly and disabled experiencing frequent or recurring problems with their health which puts them at significant risk for hospitalization, institutionalization or significant harm. This program targets the use of the most cost effective appropriate service programs for that Consumer, allowing them to remain safely at home which would result in direct cost savings to the Department.

Addus is most familiar with the older adult (60+) population which currently accounts for 13% (~ 5M) of the State's population, of which approx 420,000 are low income. As one of two contract agency providers of IHSS in California, we strive to meet the needs of a broad range of Consumers with diverse cultural, ethnic, and socioeconomic situations. We have a unique perspective in that we work with the California Department on Aging, County Managed Independent Provider programs, Home Health Providers, PACE programs, Physicians and other community based health and social service providers. We have witnessed firsthand the lack of coordination and communication that leads to duplication of services and in some cases direct harm of the Consumer.

Through the submission of our perspective, Addus is urging the DHCS and other Agencies involved in this pilot to develop an integrated, comprehensive and coordinated network of services including experienced home and community based service providers that will integrate care internally or with other community service providers for the betterment of care to Consumers and cost savings to the healthcare system. Specifically, we would ask the Department to require one or all MCO's to utilize Addus and our Community Case Management Extension program for all or part of the pilot areas. We believe this program will improve the Consumer's health and well being, support a choice of service providers and lead to permanency for Consumers in their natural environment.

### **The Community Case Management Extension Program**

*Managed Care providers are continuously seeking ways to lower cost and improve outcomes. An important component of an effective utilization control program is accurate information, promptly related to Case Managers. Unfortunately, Medicaid Managed Care Organizations (MCO) do not possess the ability to cost effectively gather this essential information. MCO's could reduce their costs by linking with a provider of low cost in home supportive services to observe and report changes in the Consumers' condition, health or environment which may signal the need for prompt, cost effective, early intervention. These services are arguably the lowest cost care of any in the healthcare continuum and can be provided to the MCO's to ensure that enrollees have the highest quality, most cost effective services available.*

#### **Overview of the Issue**

Over the past few years states have experienced profound pressure to control costs and overcome budget deficits. Without changes to the state's revenue generating structure, the growth of current Medicaid programs will be unsustainable in future fiscal years. Accordingly, states have had to implement changes in their Medicaid budgets that include across-the-board provider and Medicaid Managed Care Organization (MCO) rate cuts and direct cuts in benefits and eligibility. Even though officials have projected that enrollment growth overall will slow in the future, there continue to be concerns about the aging population and how that will change the demographic composition of Medicaid enrollees. More elderly and disabled enrollees will translate into higher costs, even without an increase in the total number of persons on Medicaid. This indicates that additional cuts in Medicaid programs without innovation are likely.

The Medicaid population is not homogeneous and costs incurred by enrollees have wide variances. A recent study utilizing Illinois data showed that 11% of enrollees accounted for 70% of the costs incurred by the state. Conversely, the remaining 89% of enrollees accounted for just 30% of the costs, including 14% of enrollees who consumed no services at all. A Kaiser study further explored this, finding low-income children and their parents represent about 75% of all beneficiaries, but account for only 30% of spending. In contrast, elderly and persons with disabilities represent just 25% of enrollees, but account for 70% of spending, reflecting their intensive use of acute and long-term care services.

In general terms, there are a limited number of ways to control costs in the Medicaid program;

- ☐ Regulating provider rates;
- ☐ Restricting covered services;
- ☐ Restricting the number of individuals enrolled in the program; and
- ☐ Reducing the amount of services utilized.

Each of the options stated above would have the effect of curbing the growth in Medicaid costs. However, the negative effects of reducing rates and services or persons served may offset any cost savings benefit. Managing unnecessary or excessive service utilization is considered to be the most effective method for curbing the growth in Medicaid costs. Much unnecessary utilization is the result

of uninformed choices, poor coordination of services or the lack of appropriate health care resources available to the enrollee.

### ***A Community Based Case Management Approach***

Current MCO's have been patterned after more traditional systems. Enrollees are provided with a general number for information/education and web based resources or print materials to identify providers. Case Managers are available to coordinate care however, this often relies on a more "responsive" system where case management becomes involved after an action or event occurs or while an event is evolving and not as a preventative measure. In large part this is due to the availability. Case managers cannot be everywhere and cannot keep track of all their assigned enrollees. Case Managers cannot easily call patients daily, check on their clinical status, visit their homes regularly, ensure they attend physician's or other appointments, follow their diet or remind them to take their medications. An important component of any effective utilization control program is accurate information relayed promptly to Case Managers.

Addus Healthcare's Community Based Case Management Extension program targets the highest risk – highest cost patients. Utilizing non-medical in home supportive services staff, we can be at a patient's home in a matter of hours, sometimes even minutes. Our trained staff can contact the case manager to provide updates on the patient's condition or current needs avoiding costly utilization of the Emergency Room or Acute Care facilities. We can ensure that your most difficult patients are transported to physician's appointments, have adequate and appropriate nutrition, medication or other services they need to remain safely at home. We can also provide regularly scheduled "well being" checks and be the "eyes and ears" of the Case Managers. Specifically, the goals of this program include:

- Increase compliance including medication and nutritional compliance
- Regular review and report of the patient's general condition
- Breaking the cycle of dependency on ER/Acute care through regular scheduled transportation to medical and clinic appointments
- Environmental management of patients living arrangements to ensure safety and effectiveness
- Overall decreased costs for the highest acuity caseload

### ***Research***

The Care Coordination Department of Washington University in St. Louis, led by Dr. John Lynch, participated in a pilot program in conjunction with CMS. The program was designed to evaluate the impact on cost of the most expensive Medicare enrollees. Dr. Lynch's care coordination model addresses the sickest 5% in the Medicare program who accounted for 20-30% of the Medicare costs in their geography. He believes that aggressive action can produce significant cost savings and improvements to the population's overall health. The program relies on various community resources and programs to recognize a person's debilitated medicate state. These individuals are then assigned a clinical case manager who assesses their needs and formulates a care plan specifically suited to the individual. The model relied heavily a social/community based service infrastructure for early detection and intervention of potentially costly patients. The pilot program ended in 2005 and the program's experience suggests "that many high-risk Medicare patients could benefit from an integrated care

management intervention that overcomes medical and nonmedical gaps in their care and other barriers”.

### ***MCO Support***

Addus is uniquely positioned as both a clinical provider of home health services and a provider of social model supportive personal care. We can assist Consumers to access these support services through an integrated services approach, thereby reducing service duplication, reducing overall costs while providing superior outcomes. We will do this by working with the Case Manager to identify a Consumer’s specific barriers to accessing care and then developing a plan to address them. This may include a simple telephone call for reassurance or to remind a Consumer to take or pick up medications, transportation to their physicians appointment or regular in-home supportive services to ensure dietary compliance. Our staff will provide regular follow up and reporting to the MCO so Case Managers are able to make informed decisions about a Consumer’s care plan with up to date information on their health status. Addus will work with the MCO’s staff to provide ongoing monitoring and support of the member through activities designed to keep the member compliant with the care plan, reducing the need for hospitalizations or unexpected and costly interventions. The on-going monitoring and reporting can take place in real time using our current system of point of care devices that deliver routine reports and change in condition observations electronically.

### ***Case Example/Costs***

Chronic heart disease patients can be cost effectively maintained at home through a combination of required modified behavior, proper diet and medication management. Failure of the patient to maintain a proper diet or continuation of contributing behaviors or the failure to take medications as prescribed general will result in frequent and recurring hospital admissions. The average cost of a cardiac admission to an acute care facility is approx. \$8,000. A visit by a non-licensed home support worker trained by a specialist to observe and report accurately on changes in the patient’s condition or environment costs approximately \$32.00. In order to be cost effective, this program would have to deflect one acute care admission for every 200 visits made.

Addus approached this challenge as not just a proposal to provide services, but as an opportunity to present a framework for developing an innovative and evolutionary service delivery model. We are proposing a consumer centered system with less focus on the traditional “service lines” and more focus on service delivery across a continuum to achieve outcomes. This will be done through the use of technology, centralization of care management, utilization of the most cost efficient services and re-distribution of resources.

Addus has had experience operating under this model for over 10 years in both managed care and fee for service environments. We have provided IHSS in a capitated arrangement and were able to demonstrate cost savings to the program through better care coordination. We have implemented technology to support our goals including both a unified scheduling, service and billing system (the McKesson Horizon Homecare system) and a field based telephony reporting tool that allows are thousands of field staff to report the consumer’s condition in real time using text, pictures or video to clinical staff who can proactively assess the Consumer, potentially avoiding more costly care.

We can achieve this through use of our experienced stable, in home workforce. Addus has a long history working with unions and over the past 25 we have developed a strong partnership with Service Employees International Union (SEIU). Addus just recently signed its third national agreement with SEIU and has active agreements with ASCFME and UDW. Through our union partnerships we have gained the ability recruit stable, reliable and high quality work force with a low 20% employee turnover (after the first 90 days) and with 39% of our home and community based employees have been with Addus over 3 years. Addus is also one of only nine US companies recognized by the AFL/CIO for its successful partnership between employer and labor unions.

While we would encourage the Department to implement these concepts within the program framework under any circumstances, the advantages of selecting our organization to work with the MCO’s chosen under this pilot include:

- Over 30 years of experience backed by a nationally recognized, financially stable company
- Over 20 years of experience providing services under an community based integrated services approach
- Experience providing In-home Aide services to eligible Elderly and Disabled Waiver in-home support services Consumer in California and in 18 other states
- Proven track record of successful contracting for county, state and federal government funded programs
- Commitment to improve quality of life for Consumers regardless of socio-economic means
- Dedicated, compassionate care staff with solid training, delivering services to meet Consumer needs
- Delivery support mechanisms; like language resources, telephony, automated systems and consumer monitoring tools
- Established Quality Assurance and Quality Improvement programs in place to help ensure customer satisfaction and contract compliance
- Strong relationships with organized labor

Questions for Interested Parties (including potential contracted entities): (please limit to 10 pages)

1. What is the best enrollment model for this program?

Addus would not be directly involved in Consumer enrollment. Addus would encourage an RFI/RFP process for MCO provider selection or encourage an open enrollment process requiring providers to commit to specific standards that ensure integration of services.

2. Which long-term supports and services (Medi-Cal and non-Medi-Cal funded) are essential to include in an integrated model?

We believe the utilization of IHSS as well as a full complement of community based supportive services such as nutritional support, telephone reassurance, adult day services, transportation etc are essential to achieving positive Consumer and meaningful fiscal outcomes

3. How should behavioral health services be included in the integrated model?

Mental health services require a highly specialized team and community based support. While these Consumers are often also being provided “traditional” services under Medi-Cal, their behavioral support services should be overseen by a provider or contractor who specializes in behavioral health management.

4. If you are a provider of long-term supports and services, how would you propose participating in an integration pilot? What aspects of your current contract and reimbursement arrangement would you want to keep intact, and what could be altered in order to serve as a subcontractor for the contracted entities?

Addus HealthCare is the largest contracted provider of IHSS in California. We would propose participating in all the pilot areas as a provider of homemaker, personal care, attendant care, respite care and transportation as well as a provider of Certified Home Health Services. We believe as outlined above, this service is most effective as part of an integrated in home services/case management extension program.

5. Which services do you consider to be essential to a model of integrated care for duals?

The specific monitoring and support activities Addus would consider “essential” include:

- Comprehensive Care Coordination and IHSS
  - Attendant Care
  - Respite
  - Personal Care
  - Homemaker
- Skilled Home Health

- Skilled Nursing
- Therapy Support (Physical Therapy, Occupational Therapy, Speech Therapy)
- Registered Dieticians
- Social Workers
- Home Health Aides
- Physician Appointment Scheduling and Assistance
  - Tracking Appointment
  - Reminder Phone Call
- Transportation
  - Coordination with Case Manager
  - Transportation
  - Errand Assistance
- Linkages and Community Outreach
  - Adult Day Services
  - Title III
  - Substance Abuse Programs
  - Senior Center (s)
  - Ombudsman/Legal Assistance Services
- Nutritional Services
  - Meal Prep and Planning
  - Home Delivered Meals
  - Grocery Shopping
  - Nutritional Education
- Medications
  - Medication Reminders
  - Ensuring Medications are in Home
  - Supporting Compliance
  - Reporting/Observing Changes

6. What education and outreach (for providers, beneficiaries, and stakeholders) would you consider necessary prior to implementation?

Essential education for successful implementation of a pilot program in California would include the basics of person centered care planning, the benefits and fundamental objectives of integration of services, and the desired outcomes both Consumer, provider and fiscal that are expected from the pilot project.

Addus Healthcare has been involved in the implementation of a similar Managed Medicaid program in New Mexico and is currently involved in a transition in New Jersey. In both cases the lack of information in the provider community resulted in the dissemination of incorrect information to the Consumers involved. Early engagement of the provider community that will be involved in the ongoing care of the Consumers and repeated letters and information sent to the Consumers outlining the process for transition will help keep all stakeholders informed.

7. What questions would you want a potential contractor to address in response to a Request for Proposals?

How the provider would achieve the outcomes identified from project developers and Administration as well as the capacity of the agency to serve the populations identified and their specific understanding of the needs of that population

Proposers should be asked to provide a transition plan and timelines, overview of their past history and experience in transitioning the elderly and disabled populations, provide examples of educational materials for Consumers, how they specifically expect to achieve cost savings (what services would they see expanding and what services would be restricted)

8. Which requirements should DHCS hold contractors to for this population? Which standards should be met for cultural competency, sensitivity to the needs of the dual eligible population, accessibility, etc., prior to enrolling beneficiaries?

Current requirements for accessibility and competency under Medicaid and the related waivers under which these services are currently provided should be the minimum requirement for all contractors.

9. If not a potential contractor, what are you able to contribute to the success of any pilot in your local area?

As outlined in the program statement above, Addus HealthCare could be a significant catalyst for any contractor's success. Our position as a large national IHSS provider, having experience with this specific population under many different programmatic structures including managed care makes us a unique part of this program. Addus could work within all four of the proposed pilot areas providing the same support to all the potential contractors. Our integrated care model would provide the necessary bridge from the MCO to the community as well as assist the chosen Managed Care Entity with managing the consumers care, providing

10. What concerns would need to be addressed prior to implementation?

Reimbursement and payment terms, standards for compliance as well as the identification on outcomes and objectives for the project

11. How should the success of these pilots be evaluated, and over what timeframe?

In addition to utilization data (rates of hospitalization, utilization of community based services, utilization of emergent services and pharmaceutical utilization), overall costs of care and Consumer satisfaction.

12. What potential financial arrangements for sharing risk and rate-setting are appropriate for this population and the goals of the project? What principles should guide DHCS on requiring specific approaches to rate-setting and risk?

Depending on outcome and provider network both fee for service or capitation (risk sharing) are appropriate for this project. Guiding these decisions is the ability of the provider to effectively manage risk without sacrificing quality and the position of the provider in the continuum of care.